

☐ **CONDITIONAL RELEASE**    ☐ **SUPERVISED RELEASE**

**INVOICE**

Completion of the form is required for reimbursement of services.

Name—Patient (Last, First MI)	ID Number	Invoice Period (Month/Year)
<b>CATEGORY</b>	<b>COSTS FOR MONTH</b>	<b>COSTS YEAR TO DATE</b>
Communication		
Equipment		
Insurance / Liability		
Miscellaneous Costs		
Postage		
Rent / Occupancy		
Salaries / Benefits		
Sub-Contract Costs		
Supplies		
Support Services Salaries / Benefits		
Training / Professional Fees		
Travel		
<b>SUB-TOTAL DIRECT SERVICES</b>		
Indirect Administrative Costs		
<b>GRAND TOTAL</b>		
Name - Reporting Agency	Name - Authorized Agency Representative	
<b>SIGNATURE</b> - Authorized Agency Representative	Date - Signed	Date - Submitted